

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

**CORPORATION  
REINSTATEMENT**



FLORIDA DEPARTMENT OF STATE  
Secretary of State  
DIVISION OF CORPORATIONS

**FILED**

07 FEB 12 AM 8:49

SECRETARY OF STATE  
TALLAHASSEE, FLORIDA

**REINSTATEMENT 05-07**

**DOCUMENT #**

1. Corporation Name **SOUTH BROWARD REHAB MEDICAL  
CENTER OF PLANTATION, INC**

Doc# **P04 0000 33956**

**2. Principal Office Address - No P.O. Box #**

**200 SW 27th AVE**

**3. Mailing Office Address**

**12677 CLASSIC DR.**

**Suite, Apt. #, etc.**

**Suite # 208**

**Suite, Apt. #, etc.**

**City & State**

**FT LAUDERDALE, FLA.**

**City & State**

**CORAL SPRINGS, FLA.**

**Zip**

**33312**

**Country**

**U.S.A.**

**Zip**

**33071**

**Country**

**U.S.A.**

CR2E081 (1/07)

**4. Date Incorporated or Qualified  
To Do Business in Florida**

**2/19/04**

**5. FEI Number**

☒ Applied For  
☐ Not Applicable

**6. CERTIFICATE OF STATUS DESIRED**

☐ \$8.75 Additional Fee required  
for a Certificate of Status

**7. Name and Address of Current Registered Agent**

**Name**

**DR. NEIL GILWIT**

**Street Address (P.O. Box Number is Not Acceptable)**

**200 SW 27th AVE**

**Suite, Apt. #, Etc.**

**# 208**

**City**

**FT. LAUDERDALE**

**State**

**FL**

**Zip Code**

**33312**

☒ The reinstatement fee is imposed, except in  
circumstances which the entity did not receive  
the prior notices. By checking this box, you  
are certifying the prior notices were not  
received and requesting the reinstatement  
fee be waived.

**CHANGED ADDRESS - DID NOT  
RECEIVE NOTICE IN 2005**

**8. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of section 607.0505 or 617.0503, F.S.**

Signature of  
Registered Agent

REGISTERED AGENT MUST SIGN

Date

**2/7/07**

**9. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)**

Titles	Name of Officers and/or Directors	Street Address of Each Officer and/or Director	City / State / Zip
PRES.	DR. NEIL GILWIT	200 SW 27th AVE FT. LAUD., FL 33312	FT. LAUD, FL 33312

**400088908614**

02/21/07--01030--018 \*\*450.00

**10. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filing this reinstatement application, the reason for dissolution has been eliminated, the corporate name satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption contained in Chapter 119, F.S. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.**

**SIGNATURE:**

**DR. NEIL GILWIT**

SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

**2/7/07**

Daytime Phone #

**(954) 581-2727**

*jc 2/14*